Second Quarter 2000 Summary of Incidents, Complaints, Enforcement Actions

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NOTE: Items within these summaries have been redacted (blackened out) due to confidential medical information under the Medical Practice Act and The Texas Public Information Act.

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SUMMARY OF INCIDENTS FOR SECOND QUARTER 2000

I-7590 - Dose Irregularity - River Oaks Imaging - Houston, Texas

On April 3, 2000, the Licensee notified the Agency of a dose irregularity that occurred on March 22, 2000. A patient was [redacted] When the referring physician reviewed the results of the study, he notified the Licensee that a [redacted] had been prescribed. The patient had mistakenly informed the scheduling office that a [redacted] procedure was necessary. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the Licensee implemented a procedure whereby nuclear medicine studies are not initiated unless a physician has approved the study.

File Closed.

I-7591 - Abandoned Source - Baker Hughes Oilfield Operations - Houston, Texas

On April 5, 2000, the Licensee notified the Agency that three sealed sources were abandoned downhole in Lavaca County after three unsuccessful recovery attempts. The sources were 2.0 curies of cesium-137, 0.8 microcuries of cesium-137, and 18 curies americium-241. The sources were abandoned at a depth of 12,180 feet and immobilized by red dyed cement to a depth of 11, 167 feet. The sources were abandoned in accordance with Railroad Commission of Texas Rule 35 and Texas Regulations for Control of Radiation, 25 TAC §289.253.

File Closed.

I-7592 - Radioactive Material Lost - TN Technologies - Round Rock, Texas

On April 10, 2000, the Licensee notified the Agency that an x-ray fluorescense unit containing a 0.4 millicurie cadmium-109 source and a 0.1 millicurie iron-55 source could not be located on April 7, 2000. The analyzer was received in the Licensee's shipping area on January 17, 2000. The shipper was contacted to verify the tracking number and to determine how the unit was packaged by the international customer. An inventory check determined the unit was not in the Analyzer Department nor in the Technical Services Department. A plant walk through also failed to locate the unit. No procedural changes were made. The Licensee will continue to search and alert employees of the loss. The Licensee was cited for failure to maintain control of radioactive material.

File Inactive.

I-7593 - Radioactive Material Lost - Memorial Health System - Lufkin, Texas

On April 12, 2000, the Licensee notified the Agency of the loss of a 2.6 microcurie Co-57 gamma reference source. The source is believed to have been accidently thrown in the non radioactive trash. A search of the trash did not locate the source. The local landfill did not report an alarm on detectors at the landfill. The Licensee discussed the incident with all employees during their monthly radiation safety meeting. New procedures implemented to prevent a recurrence include double checking that the source is returned to its container after use and prior to being put into storage and by holding technologists responsible for sources during handling, use, and return to storage.

File Closed.

I-7594 - Badge Overexposure - Scott & White - Temple, Texas

On April 3, 2000, the Registrant notified the Agency of a 39,029 millirem exposure to a technologist during the January 2000 monitoring period. The Registrant believed the exposure was only to the badge. The badge processor noted a static exposure indicating there was no motion and the badge was not worn during the exposure. An Agency investigation concurred with the Registrant's findings. A deletion was granted and an minimal assessment, based on exposure history, was accepted.

File Closed.

I-7595 - Badge Overexposure - Non-Destructive Inspection, Corporation - Clute, Texas

On April 14, 2000, the Licensee notified the Agency of 5,325 millirem exposure to a radiographer during the February 20, through March 19, 2000, monitoring period. An Agency investigation determined it was likely that, while off work, the radiographer had left his badge, pocket dosimeter, and alarming rate meter in a radiography truck that was used on several occasions by other radiographers. There was no evidence that the worker had received the dose recorded on his badge. A deletion was granted and a 193 millirem assessment, based on pocket dosimeter records for the exposure period, was accepted.

File Closed.

I-7596 - Badge Overexposure - Howmet Aluminum - Hillsboro, Texas

On March 7, 2000, the Registrant notified the Agency of a 6,535 millirem exposure to an employee on January 17, 2000. The employee dropped his badge into an x-ray cabinet where it was subsequently exposed to radiation. The employee was moving large parts in and out of the cabinet when one of the parts knocked the badge from the shirt collar where it had been clamped. The badge was not found until the end of the work shift. The employee's pocket dosimeter indicated a zero exposure for the work day. A deletion was granted and an minimal assessment, based on past average exposures, was accepted.

File Closed.

I-7597 - Dose Irregularity - Syncor International Corporation / Methodist Healthcare System of San Antonio d.b.a. Metropolitan Methodist Hospital - San Antonio, Texas

On April 17, 2000, the Licensee notified the Agency of two dose irregularities that occurred on April 14, 2000, due to the delivery of [redacted] mislabeled as [redacted]. The prescriptions for the radiopharmaceutical were written for [redacted] yet were inadvertently placed with other syringes to be filled with [redacted] during the pharmacy set-up procedure. The pharmacist failed to double check the setup prior to dispensing. The patient and referring physician were notified of the error. The whole body dose was less than 5 rem and no organ received greater than 50 rad. In order to prevent a recurrence of this incident all pharmacists and dispensing personnel at the nuclear pharmacy were counseled regarding the set-up checking policy and its importance in filling prescriptions with the right product. A Notice of Violation was issued to the nuclear pharmacy. A report of the error by the pharmacy has been forwarded to the Texas State Board of Pharmacy for possible action under state pharmacy rules.

File Closed.

I-7598 - Badge Overexposure - Hendrick Medical Center - Abilene, Texas

On April 18, 2000, the Registrant notified the Agency of a 14,676 millirem exposure to a student technologist during the February 2000 monitoring period. The Registrant believed the exposure was only to the badge. The student worked under direct supervision for the entire nine month program. The student was observed during clinical procedures using appropriate radiation safety precautions. Two months involved a clinical rotation wherein only seven fluoroscopic procedures were performed. The workload involved limited exposure. A deletion was granted and a 100 millirem assessment, based on co-worker's past average exposures, was accepted.

File Closed.

I-7599 - Badge Overexposure - Hendrick Medical Center - Abilene, Texas

On April 18, 2000, the Registrant notified the Agency of a 13,060 millirem exposure to a student technologist during the February 2000 monitoring period. The Registrant determined that the student had worn her dosimeter on a length of strap around her neck rather than attached to her clothing. Due to her height, the length of the neck strap, and the likely location of the patient relative to her and the neck strap, it was suspected that the dosimeter entered the beam during fluoroscopic procedures. The Registrant requested a dose assessment of 10% of the recorded dose. A deletion was granted and a 1,306 millirem assessment was accepted. As a corrective action the Registrant has counseled the student to wear her dosimetry badge on her collar.

File Closed.

I-7600 - Dose Irregularity - Valley Nuclear Incorporated / Dolly Vansant Hospital - Mission, Texas

On April 10, 2000, the Licensee notified the Agency of a dose irregularity that occurred on April 6, 2000. A [redacted] was administered to a patient. Upon imaging the [redacted], it appeared the product was not of acceptable quality. The hospital notified the pharmacy and the quality of the product was rechecked indicating a tagging efficiency of 74%. The pharmacy believes a breakdown of the [redacted] kit took place. The pharmacy removed the product from inventory and disposed of it.

File Closed.

I-7601 - Lost Radioactive Source - Fiesta Lincoln Mercury Dodge - San Antonio, Texas

On March 5, 2000, the company notified the Agency that a static eliminator containing polonium-210 was missing from inventory since November 1, 1999. The body shop where the source was used was closed on November 20, 1999, and an inventory discovered the source was missing. The source was not located.

File Closed.

I-7602 - Dose Irregularity - Shannon Medical Center / National Central Pharmacy - San Angelo / Abilene, Texas

On April 24, 2000, the Licensee notified the Agency of a dose irregularity that occurred on April 3, 2000. A [redacted] dose labeled with an incorrect activity was delivered to a medical center. The activity was labeled as [redacted], but was actually [redacted] when assayed by the hospital's technologist. The activity of the dose was reduced by the technologist and administered without complications. To prevent a recurrence, the pharmacy counseled the pharmacists to be more careful when assaying and preparing doses. A report of the error by the pharmacy has been forwarded to the Texas State Board of Pharmacy for possible action under state pharmacy rules.

File Closed.

I-7603 - Radioactive Material Leaking - SPECTRO d.b.a. ASOMA Instruments - Austin, Texas

On April 25, 2000, the Licensee notified the Agency of a leaking 4 millicurie Fe-55 sealed source that was discovered in a shipment returned by an overseas customer. The leaking source was isolated and placed in storage pending disposal. The transport container was tested for contamination and found not to be above the minimum detection limit of 360 picocuries.

File Closed.

I-7604 - Exposure to the Public - Dow Chemical Company - Freeport, Texas

On April 24, 2000, the Licensee notified the Agency of exposures to members of the public that occurred on March 29, 30, 31 & April 11, 2000. Five individuals were allowed to work inside a vessel while the shutter to a level gauge containing a 120 millicurie cesium-137 source was in the open position. On March 29, 2000, two scaffold builders were permitted to build a scaffold inside the vessel. On March 30 &31, 2000, two boilermakers were permitted to enter the vessel to do work. On April 11, 2000, one scaffold builder entered the vessel to remove the scaffolding. The scaffold builders and the boilermakers were given a permit to enter the vessel. However, the proper lockout procedures had not taken place. The plant makes a practice of hanging a lock at the base of the source to be used for locking out the shutter. At the time of the entry, plant operations personnel had visually looked at the source, saw the lock and assumed that the shutter had been locked out. The locking out of shutters is performed by instrument technicians who have been trained to handle radiation sources. The work inside the tower had been completed when the instrument technician realized the source had not been locked out. He determined that the work on the vessel had been performed with the shutter in the open position. The worst case exposure for the scaffold workers was calculated at 48 millirem and the worst case for the boilermakers was 16 millirem.

File Closed.

I-7605 - Source Abandoned Downhole - Halliburton Energy Services - Houston, Texas

On January 25, 2000, the Licensee notified the Agency of five well logging sources abandoned downhole in a well offshore of North Padre Island. There were two 4.0 curie americium-241, one 2.0 curie cesium-137, one 1.5 microcurie cesium-137, and one 0.5 microcurie cesium-137 sources. The sources were immobilized by placement of a cement plug. The sources were abandoned in accordance with Railroad Commission of Texas Rule 35 and Texas Regulations for Control of Radiation, 25 TAC §289.253. The Licensee was issued a Notice of Violation for failure to make a written report within 30 days of the incident.

File Closed.

I-7606 - Dose Irregularity - Lake Granbury Medical Center - Granbury, Texas

On April 28, 2000, the Licensee notified the Agency of a dose irregularity that occurred on April 27, 2000. A patient scheduled for a [redacted] was inadvertently administered [redacted] instead of the prescribed [redacted]. A technologist mistakenly pulled the wrong dose from the delivery box. The error became evident when [redacted]. The technologist checked the label on the dose and confirmed the dose was labeled as [redacted] The patient and referring physician were notified of the error. The whole body dose was less than 5 rem and no organ received greater than 50 rad. The patient was [redacted]. To prevent a recurrence, the Licensee reviewed policies and procedures with the technologist and instructed the technologist to double check dose labels.

File Closed.

I-7607 - Badge Overexposure - Memorial Hermann Baptist - Beaumont, Texas

On June 6, 2000, the Registrant notified the Agency of a 7,212 millirem exposure to a student technologist during the March 1, through April 30, 2000, monitoring period. An Agency investigation determined that the badge had a static exposure. Corrective actions included: instruction on the proper use and storage of personal dosimetry badges; counseling of the individual; and increased monitoring of dosimetry reports to determine program aberrations as they occur. A deletion was granted and an 8 millirem assessment, based on the individual's past exposure, was accepted.

File Closed.

I-7608 - Dose Irregularity - Shannon Medical Center - San Angelo, Texas

On May 30, 2000, the Licensee notified the Agency of a dose irregularity that occurred on May 5, 2000. A patient was administered [redacted] instead of the prescribed [redacted]. While dictating the examination, a staff radiologist noticed the dose was assayed on the wrong window setting. A contract technologist had incorrectly set the dose calibrator on the [redacted] window. The patient and the referring physician were notified of the error. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the Licensee will closely supervise contract technologists.

File Closed.

I-7609 - Dose Irregularity - Columbia Medical Center of Denton Subsidiary LP d.b.a. Denton Regional Medical Center - Denton, Texas

On June 13, 2000, the Licensee notified the Agency of a dose irregularity that involved the [redacted] instead of the prescribed [redacted]. The error occurred when a technologist hurriedly grabbed the wrong syringe, assayed it in the facility dose calibrator, and failed to check the radiopharmaceutical label. The patient and referring physician were notified of the error. The whole body dose was less than 5 rem and no organ received greater than 50 rad. The patient [redacted] The technologist was formally counseled and reminded of current hospital policy and procedure concerning safe use of radioactive material. An Agency investigation of the incident concurred with the findings of the facility's radiation safety officer.

File Closed.

I-7610 - Radioactive Material Found at Landfill - Trinity Oaks Landfill - Dallas, Texas

On July 6, 2000, a landfill notified the Agency of elevated radiation levels on a residential trash truck that occurred on July 6, 2000. The truck was secured in an isolated area overnight. The following day radiation levels had decreased substantially indicating a short-lived isotope was involved. The landfill was allowed to dispose of the trash.

File Closed.

I-7611 - Overexposure - Conam Inspection - Pasadena, Texas

On June 9, 2000, the Licensee notified the Agency of a 6,500 millirem exposure to a radiographer on May 24, 2000. Work was being performed by a three man crew consisting of a trainer, radiographer, and trainee. The trainer and trainee were manipulating the crankouts and the radiographer was changing the films on a scaffold. At the conclusion of a shot, the trainer left to talk to facility employees and the trainee cranked the source to the shielded position. The trainee gave the radiographer the all clear to change the films. After changing the films, the radiographer left the scaffold and heard his alarming ratemeter. He could not hear it on the scaffold because he was wearing earplugs in a noisy area. The radiographer went to the crankouts and noted the survey meter was off scale. Neither the radiographer nor trainee had performed a survey of the camera after concluding the previous shot. The radiographer then cranked the crankout an additional turn to return the source to the shielded position. The source had been approximately 10 inches outside the camera. The radiographer's pocket dosimeter was off scale. The trainer immediately shut down the job and sent the crew's dosimeters for processing. Violations were issued to the Licensee, the radiographer trainer, the radiographer, and the radiography trainee.

File Closed.

I-7612 - Dose Irregularity - Saint David's Medical Center - Austin, Texas

On June7, 2000, the Licensee notified the Agency of a dose irregularity that occurred on June 7, 2000. A patient who was scheduled for a [redacted] was administered [redacted] The patient and referring physician were notified of the error. The whole body dose was less than 5 rem and no organ received greater than 50 rad. To prevent a recurrence, the Licensee counseled the technologist to carefully read physician's orders and to request clarification on any orders that are confusing.

File Closed.

I-7613 - Damaged Gauge - Southwestern Laboratories - Texas City, Texas

On June 8, 2000, the Licensee notified the Agency of damage to a moisture density gauge. The gauge was run over by a track hoe and partially crushed. The sources, 40 millicuries of americium-241 and eight millicuries of cesium-137, remained in the shielded position and were undamaged. The gauge technician had notified the track hoe operator that he was leaving the gauge at the side of the trench. The operator was aware of the gauge's location and thought he had clearance when the gauge was hit by the track hoe and trapped between the top of the trench and the bottom of the counter-weight of the vehicle's cab. A leak test determined that no leakage occurred. The Licensee was cited for failure to keep the gauge under constant surveillance.

File Closed.

I-7614 - Radioactive Material Found - Newell Recycling - San Antonio, Texas

On April 6, 2000, the scrap yard notified the Agency that a load of scrap had activated their radiation alarm. An Agency investigation determined the load contained a lead cylinder with no markings and radiation levels of 30 millirem per hour on contact. A wipe test of the cylinder indicated no surface contamination. Further analysis determined the cylinder contained a radium-226 source with an activity of approximately 200 microcuries. The recycling company secured the source pending disposition.

File Inactive.

I-7615 - Overexposure - Radiographic Specialists, Inc. - Houston, Texas

On June 20, 2000, the Licensee notified the Agency of a 5,755 millirem exposure to a radiographer for the May 10, through June 9, 2000, monitoring period. An Agency investigation determined that there was no evidence to indicate the exposure was not valid. A request for deletion of the dose by the Licensee's radiation safety officer was denied. The radiographer's employment was terminated. The Licensee was issued a Notice of Violation.

File Closed.

I-7616 - Badge Overexposure - Blazer Inspection, Texas City, Texas

On June 21, 2000, the Licensee notified the Agency of a 129,563 millirem exposure to a radiographer during the March 20, 2000, through the April 19, 2000, monitoring period. An Agency investigation determined the radiographer performed radiography on three days during the monitoring period. The radiographer's badge was stored in a personal locker when not in use. The radiographer received 55 millirem and 33 millirem exposures, respectively, during the January and February 2000 monitoring periods. Co-worker exposures were also low. The Licensee believed the exposure was only to the badge. A deletion was allowed and an assessment of 420 millirem, based on a regulatory allowance when badge records are unavailable, was accepted.

File Closed.

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SUMMARY OF COMPLAINTS FOR SECOND QUARTER 2000

C-1468 - Laser Injury - Cosmetic Surgery of the Southwest - El Paso, Texas

On April 5, 2000, an individual notified the Agency of a [redacted] that occurred during treatment for the removal of a [redacted] during the March-April 1998 time frame. The injury was alleged to have occurred during [redacted]. An Agency investigation determined the company was unregistered. A Laser Registration packet was left with the facility. Two health related violations were cited for the facility. The facility was recommended for Escalated Enforcement action.

File Closed.

C-1469 - Regulation Violation - Non-Destructive Inspection Corporation - Clute, Texas

On April 6, 2000, the Agency received a complaint alleging regulation violations by the Licensee's radiographers. During an Agency investigation, a radiographer trainer and a radiographer trainee were noted performing radiography while not wearing individual monitoring devices. It was also noted that radiation surveys of the entire circumference of the radiographic exposure device were not performed after the source was returned to the shielded position; that calibration of the trainee's alarming ratemeter exceeded one year; and that records of surveys of the exposure boundary were inaccurate. The violations by the radiographer trainer were similar to violations noted during a previous investigation. The Licensee was issued a Notice of Violation.

File Closed.

C-1470 - Exposure to Public - TXU Electric Martin Lake Plant - Tatum, Texas

On April 13, 2000, the Agency received a complaint alleging radiation exposure to members of the public, and possible contamination, occurred on April 9, 2000. A five man crew was working on top of a power unit when a fine liquid mist coming from a cooling tank soaked the workers. A "Caution Radioactive Materials" sign was posted on the tank. A survey of the workers clothing detected no contamination. An Agency investigation determined several gauges used to measure the gypsum slurry, used as a part of the plant's pollution control system, were located near where the workers had been. The gauges contained 200 millicuries of cesium-137 on a 12/01/83 assay date. A "Caution Radioactive Materials" sign was posted adjacent to the location of the gauge. Radiation levels of 1.2 millirem per hour were measured at one foot from the gauge. There were also indications of leakage of the gypsum slurry from lines in the immediate vicinity. The investigation determined no incident of contamination took place. The workers were unfamiliar with the use of nuclear gauges at the facility. The Licensee indicated that the safety training would be checked to assure that contractors are informed of the nuclear gauges and provided the necessary radiation safety information.

File Closed.

C-1471 - Uncredentialed Technologist - James E. Downs, D.D.S. d.b.a. Saginaw Dental Services - Saginaw, Texas

On April 24, 2000, the Agency received a complaint alleging the Registrant used an uncredentialed technologist and unnecessary exposure to patients and staff of the facility due to failure to use personnel protective equipment while performing dental x-ray. An Agency investigation determined the technologist was credentialed through the Texas Board of Dental Examiners. Lead aprons were available and all were in serviceable condition. Written Operating and Safety Procedures indicated that the aprons were to be used for all patients undergoing dental x-ray procedures and that during the procedure no staff personnel or family members were to be allowed to stay in the room.

File Closed.

C-1472 - Regulation Violation - Alamo City Imaging - San Antonio, Texas

On April 6, 2000, the Agency received a complaint alleging that a Registrant provided copies and not originals of mammograms for comparison purposes. An Agency investigation determined that a patient and not the Registrant supplied the facility with the copies. The Registrant had sent the copies to the patient on March 22, 2000. The Registrant was unaware that the patient intended to use the films for comparison purposes at the other facility. The Agency was unable to substantiate any instances of the Registrant sending copies for comparison purposes.

File Closed.

C-1473 - Regulation Violations - Bering Dental Clinic - Houston, Texas

On April 1, 2000, the Agency received an anonymous complaint alleging that the Registrant had not performed equipment performance evaluations since April 26, 1996, and protective aprons were in poor condition. An Agency investigation determined that two equipment performance evaluations had been performed since the last Agency inspection and that the lead aprons were in good condition. However, the facility radiation safety officer had departed the facility on approximately March 1, 2000, without appropriate notification to the Agency. The Registrant was cited for the violation.

File Closed.

C-1474 - Regulation Violations - Diagnostic Swallowing Services - Sulphur Springs/San Antonio, Texas

On May 1, 2000, the Agency received a complaint alleging a Registrant was in violation of personnel monitoring and equipment compliance regulations during operation of a mobile x-ray fluoroscopic unit. An Agency investigation determined the Registrant failed to conduct equipment evaluations as is required. Operating and safety procedures, current copies of the regulations, and documentation of completion of equipment performance evaluation and corrective actions were not maintained on the mobile van as is required. The registrant was cited for these violations.

File Closed.

C-1475 - Regulations Violations - GCT Inspection, Inc. - South Houston, Texas

On May 22, 2000, the Agency received an anonymous complaint alleging that the Licensee's employees were performing radiography that resulted in the exposure of a radiographer; that a camera was left unsecured at the facility; that a damaged camera was being used by the Licensee, and that an unauthorized permanent storage location was being used for radiography cameras. An Agency investigation confirmed that an exposure device was left unsecured overnight at a facility on May 14, 2000, and that the Licensee had failed to notify the Agency immediately upon learning of the loss of control of the radiography camera. The other allegations could not be substantiated. The Licensee was cited for the violation.

File Closed.

C-1476 - Regulation Violations - Doctors Hospital-Tidwell - Houston, Texas

On May 23, 2000, the Agency received an anonymous complaint alleging a Registrant allowed technologists to perform dangerous and hazardous procedures not authorized by their credentials. An Agency investigation substantiated the allegation. The Registrant was cited for the violation.

File Closed.

C-1477 - Regulations Violations - Doctor's Hospital Parkway - Houston, Texas

On May 23, 2000, the Agency received an anonymous complaint alleging that dangerous and hazardous procedures were being performed by personnel possessing only a Limited Medical Radiological Technologist (LMRT) certificate. An Agency investigation determined that the only LMRT employed by the facility had an expired certificate. This technologist's duties were changed to assist with, but not to perform x-ray procedures and he was later transferred out of the department. A review of patient logs did not indicate any procedures performed by the technologist since the expiration of his certificate. The allegations could not be substantiated.

File Closed.

C-1478 - Regulation Violations - Petroleum Industry Inspectors - Houston, Texas

On June 2, 2000, the Agency received an anonymous complaint alleging: documents had been falsified to indicate radiographic exposures were made when none were made; a possible exposure above the allowed limit occurred on the night shift, May 31- June 1, 2000, during an equipment problem; and a radiographer did not wear dosimetry equipment while performing radiographs but deliberately exposed the dosimeter to make it appear the badge had been worn. An Agency investigation could not substantiate the allegations. In response to the allegation of falsifying exposures, radiographers recalled instances of repeat exposures due to initial exposures that resulted in dark films. At 7:15 am on May 30, 2000, a source was cranked to the shielded position but would not lock into place. A damaged part was found on the crankout equipment. The crankout equipment was sent to the manufacturer for repair. The pocket dosimeter reports indicated the four radiographers involved with the job received radiation doses as follows: 130, 20, 10, and 2 millirems. No excessive exposures were reported. No deliberate exposures to dosimetry was substantiated.

File Closed.

C-1479 - Public Exposure to Radiation - Mesquite, Texas

On May 11, 2000, the Agency received a complaint forwarded by the Nuclear Regulatory Commission alleging that a transformer contained radioactive material. The location of the transformer or any other information was not provided. Agency attempts to contact the complainant for more information were unsuccessful. Further actions could not be taken.

File Closed.

C-1480 - Regulation Violation - Heart Hospital - Austin, Texas

On June 13, 2000, the Agency received an anonymous complaint alleging: a radiograph was performed in May of 2000, with a mobile x-ray unit that was not functioning properly; the radiograph produced was not of diagnostic quality; and the facility was aware of problems with the unit but waited until after the radiograph to make repairs. An Agency investigation determined no items of noncompliance for either of the two units in use at the facility. Service records were reviewed for both units from the installation date until the present. The complaint could not be substantiated.

File Closed.

C-1481 - Regulation Violation - RWR Company LLC d.b.a. SomaBel - Edinburg, Texas

On June 13, 2000, the Agency received an anonymous complaint alleging that a Registrant was violating Agency laser rules. The allegations were: that the physician was not prescribing the laser treatments; that the Registrant was operating without standing orders; that the physician has little or no direct involvement with the laser treatment facility but practices in his speciality across town; that the physician does not supervise laser operators while performing laser treatments; and that several patients had been burned during laser treatments without notification to the Agency. An Agency investigation, in conjunction with the Texas State Board of Medical Examiners, and the Texas Department of Health's Bureau of Food and Drug Safety, Division of Medical Devices, determined that detailed standing orders were in place at the facility and that they were signed and updated annually by the physician. Prescriptions for laser treatments were annotated in each patients record but had not been signed by the physician. One patient was [redacted], which was not reported to the Agency within 24 hours of the occurrence. Other allegations could not be substantiated. The Registrant was cited for the violation. A report of the allegations has been forwarded to the Texas State Board of Medical Examiners for possible action under that Agency's rules.

File Closed.

C-1482 - Regulation Violation - Cosmetic Laser Center - McAllen, Texas

On June 14, 2000, the Agency received an anonymous complaint alleging that a facility was performing laser treatments with an unregistered laser. The complainant further alleged that the facility had burned patients with the laser equipment. An Agency investigation determined that two lasers had been in use at the facility since November 15, 1999, and the lasers were not registered. No laser burns could be confirmed. An application for registration was given to the physician. The facility was cited for failure to submit an application for registration within thirty days of commencement of operation with a laser for use in the healing arts.

File Closed.

C-1483 - Regulation Violation - Petrochem Inspections Services - Houston, Texas

On June 7, 2000, the Agency received an anonymous complaint alleging that the Licensee had no security; had left a radiographic camera in an unrestricted area; and that a visitor to the facility was sprayed during the wash out of a company truck which resulted in personal contamination of 4-5 rads. The complainant further alleged that the company radiation safety officer (RSO) was absent and had no knowledgeable assistant while the RSO was absent. An Agency investigation determined that security was adequate. The investigation further determined that the camera was a dummy device that was used by the Licensee for training purposes. This device contained no radioactive material and was used to demonstrate pigtail movement. No loose materials are possessed by the firm and no knowledge of a contamination incident had been noted by or reported to the Licensee. The RSO was on vacation during May 13 - 20, 2000, however, no radiography was performed.

File Closed.

C-1484 - Regulation Violation - Crystal Woman Foundation - Seabrook, Texas

On April 25, 2000, the Agency received a complaint alleging a Registrant produced mammograms of such poor quality that a [redacted] in a [redacted] was barely apparent. An Agency investigation determined the facility failed to maintain compliance with the standards for clinical image quality established by the facility's accreditation body. The U.S. Food and Drug Administration concurred with the American College of Radiology's review and overall assessment that the facility's practices posed a serious risk to human health. The Agency directed the facility to notify patients and explain the failure of their system and the potential consequences to the patient. The investigation found numerous violations of Agency regulations with high severity levels for which the Registrant was cited. As a result, the Registrant was referred to escalated enforcement with recommendations for assessment of administrative penalties. The Registrant was unable to achieve compliance and ceased operations involving mammograms.

File Closed.

C-1485 - Regulation Violation - MGM Well Services, Inc. - Corpus Christi, Texas

On June 22, 2000, the Agency received an anonymous complaint alleging that radioactive sources were not being stored in accordance with regulatory requirements and were not secure from unauthorized removal during non-duty hours. An Agency investigation determined that sources were not adequately stored when it was known that the sources would be used the following day. The only security device for the materials was a padlock on the transport container. However, this padlock would not prevent theft of the entire transport container. The Licensee was cited for the violation.

File Closed.

C-1486 - Regulation Violation - Edinburg Women's Center, P.A. - Edinburg, Texas

On June 22, 2000, the Agency received an anonymous complaint alleging that the facility was performing bone density scans that were not authorized by a physician and was performing bone density screening without Agency authorization. An Agency investigation determined that the sole operator of the bone densitometer was appropriately credentialed as a certified Medical Radiologic Technologist. All bone density scan records contained documentation to show the physician's orders. No evidence of screening was noted.

File Closed.

C-1487 - Regulation Violation - Luling Perforators, Inc. - Luling, Texas

On May 31, 2000, the Agency received a complaint forwarded by the Texas Natural Resource Conservation Commission alleging that a truck displaying radioactive placards and the company name Luling Perforators, Inc. was parked in a residential area. There was also a concern that radioactive/hazardous waste may be disposed of in the area. An Agency investigation determined that the facility was the Licensee's authorized storage location. No indications of radioactive or hazardous waste was noted at the facility.

File Closed.

C-1488 - Excessive Levels on Package - Bush International Airport - Houston, Texas

On June 19, 2000, the Agency received a complaint alleging that packages shipped through the airport contained excessive levels of radiation. The intensity of the radiation fields from two packages caused customs inspector's radiation detection devices to alarm and indicate maximum readings. An Agency investigation determined the Type A cardboard boxes were intact and labeled appropriately. Shipping papers indicated oil well tracer materials, iridium-192, scandium-46 , and antimony-24 with a combined activity of 240 millicuries were in the boxes. A radiation survey was consistent with the labeled activity. Wipe tests confirmed no contamination on the external surfaces of the boxes. No discrepancies were noted with the shipment. The packages were released to be shipped to their intended destination.

File Closed.

C-1489 - Unregistered Laser - The Cosmetic Laser Center - Edinburg, Texas

On June 28, 2000, the Agency received an anonymous complaint alleging that an unregistered laser facility was in operation and that a patient had been burned by a laser during a hair removal procedure. An Agency investigation determined that the facility had five unregistered lasers. There was no indication that a patient had been burned or had complained to the facility. The facility was cited for failure to register lasers in use at the facility.

File Closed.

C-1490 - Unauthorized Storage Locations - Tulsa Gamma Ray - Tulsa, Oklahoma

On June 15, 2000, the Agency received an anonymous complaint alleging a reciprocity Licensee had an unauthorized storage location within Texas. An Agency investigation substantiated the allegation. The Licensee was cited for unauthorized storage of radioactive material and not notifying the Agency in writing at least three days prior to performing radiography in Texas.

File Closed.

C-1491 - Unregistered Laser - Lasique - Austin, Texas

On June 30, 2000, the Agency received an anonymous complaint alleging that an unregistered laser facility was in operation. An Agency investigation determined that two unregistered lasers had been in operation at the facility since May 17, 2000. The facility operator believed that his equipment had been registered by the provider of equipment. The facility was cited for failure to register the laser equipment within 30 days of commencement of laser operations.

File Closed.

INCIDENTS CLOSED SINCE FIRST QUARTER 2000

NO INCIDENTS WERE CLOSE SINCE FIRST QUARTER 2000

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COMPLAINTS CLOSED SINCE FIRST QUARTER 2000

NO COMPLAINTS WERE CLOSED SINCE FIRST QUARTER 2000

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APPENDIX A

SUMMARY OF HOSPITAL OVEREXPOSURES
REPORTED DURING THE SECOND QUARTER 2000

NO HOSPITAL OVEREXPOSURES WERE REPORTED DURING SECOND QUARTER 2000

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APPENDIX B

SUMMARY OF RADIOGRAPHY OVEREXPOSURES
REPORTED DURING SECOND QUARTER 2000

Houston, Texas

Pasadena, Texas

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APPENDIX C

ENFORCEMENT ACTIONS FOR SECOND QUARTER 2000

Enforcement Conference: Image Partners Limited, L.L.P., dba: Coppell Diagnostic Imaging Center - Coppell, Texas - Mammography

On April 6, 2000, an Enforcement Conference was held with Healthsouth, dba: Coppell Diagnostic Imaging Center. The Registrant's representative attending the conference was Ms. Cynthia Railsback, Facility Administrator. Agency representatives attending the conference were Messrs. Rick Munoz (Chair), Thomas Cardwell, Jerry Cogburn, and Jack England and Ms. Cathy McGuire.

The conference was held as a result of the type, number, and severity level of violations noted during an Agency inspection conducted at the Registrant's facility on November 17, 1999.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notices of Violation, and the responses to the violations, were reviewed by Mr. Jerry Cogburn.

After reviewing the violations and responses, the Registrant's representative was excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. The Agency will issue a corrected Notice of Violation removing violation #1 from the Notice of Violation issued November 17, 1999.

2. It is recommended that the radiation safety officer be changed to a Healthsouth employee and that Doctor Radford should be listed as the lead interpreting physician. The Agency must be notified of these changes within 30 days of receipt of this memorandum.

3. A written commitment from Healthsouth that all interpreting physicians shall include in each mammography medical report, one final assessment category. This commitment must be submitted to the Agency within 30 days of receipt of this memorandum.

4. The Agency will increase the Registrant's unannounced inspection frequency and administrative penalties may be assessed pending the results of these inspections.

After the caucus, the Registrant's representative returned and was informed of the items discussed during the caucus. She agreed to these items and the conference was concluded.

Enforcement Conference - Universal MRI and Diagnostics - Houston, Texas - X-ray

On May 4, 2000, an Enforcement Conference was held with Universal MRI and Diagnostics, Inc. The Registrant's representative attending the conference was Tom Keefe, Vice-President of Operations. Agency representatives attending the conference were Mr. Quincy Wickson (Chair), and Madames June Ayers and Cathy McGuire.

The Conference was held as a result of the type, number, and severity level of violations noted during an Agency inspection conducted at the Registrant's facility. Of particular concern to the Agency was the fluoroscopic entrance exposure rate. A cease and desist order had been issued because the rate had exceeded twice the regulatory limit.

The participants were introduced and the procedure for conducting the conference was explained.

The violations issued in the Notice of Violation, and the responses to the violations, were reviewed by Ms. June Ayers.

After reviewing the violations and responses, the Registrant's representative was excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. A copy of the portion of the policy and procedure manual that details the 30-day requirement for correcting any discrepancies found during the routine compliance tests shall be submitted to the Agency within 30 days of receipt of this memorandum.

2. A routine compliance test, which must include measurements of the fluoroscopic entrance exposure rate, shall be performed on a new unit within 30 days of completion of installation and a copy of the compliance test shall be submitted to the Agency within 10 days of completion of the test.

3. A new application for registration shall be submitted within 10 days of the completion of installation of the new x-ray unit. This application must also reflect any changes in equipment inventory and/or status.

4. More frequent inspections shall be conducted of the facility located at 19007 Highway 59, Humble, Texas 77338. All other locations shall be inspected in accordance with their due dates. Administrative penalties may be assessed pending the results of future inspections.

After the caucus, the Registrant's representative and was informed of the items discussed during the caucus. He agreed to these items and the conference was concluded.

Enforcement Conference - N-Spec Quality Services, Inc. - Corpus Christi, Texas - Industrial Radiography

On May 11, 2000, an enforcement conference was held with N-Spec Quality Services, Inc. Licensee representatives attending the conference were Mr. Ed Criddle and Ms. Laurie McGowan. Agency representatives attending the conference were Messrs. Rick Muñoz (Chair) and Bob Green and Madames Barbara Taylor and Cathy McGuire.

The conference was held as a result of the type, number, and severity level of violations noted during an Agency inspection conducted at the Licensee's facility on February 23, 2000, and a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

The participants were introduced and the procedure for conducting the conference was explained.

The violations stated in the Notices of Violation, and the responses to the violations, were reviewed by Mr. Robert Green.

After reviewing the violations and responses, the Licensee's representative was excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. The Licensee shall provide the Agency with documentation of completion of required training for the following radiographic trainers: Michael Wilmoth, Tony Lee, Jr., Shane Weaver, and Fernando Garcia, within 30 days of receipt of this memorandum.

2. The Licensee shall provide the Agency with a written commitment that no individual will perform duties of radiographer trainee, trainer, or radiographer until all minium training requirements are met. The written commitment must be submitted to the Agency within 30 days of receipt of this memorandum.

3. The Licensee shall provide the Agency with a copy of the checklist form, used for weekly radiation survey review, within 30 days of receipt of this memorandum.

4. The Licensee shall provided the Agency with a written commitment that all in-house sources will be leak tested on the same day at intervals not to exceed six months. The written commitment must be provided to the Agency within 30 days of receipt of this memorandum.

5. The Licensee shall provided the Agency with a copy of the 3 month inspection form that must include a label check to ensure that all camera labels are legible. The information must be provided to the Agency within 30 days of receipt of this memorandum.

6. A copy of proof of successful completion of a 3 day RSO training course to be held on June 22, 2000, must be submitted to the Agency for Ed Criddle no later than July 15, 2000.

7. The Agency will increase the Licensee's unannounced inspection frequency and administrative penalties may be assessed pending the results of these inspections.

After the caucus, the Licensee's representatives returned and were informed of the items discussed during the caucus. They agreed to these items and the conference was concluded.

Enforcement Conference: Trans-America International, Inc. - Fort Worth, Texas - Nuclear Medicine

On May 23, 2000, an Enforcement Conference was held with Trans-America International, Inc. The Licensee's representative attending the conference was Dr. Mum Kasal. Agency representatives attending the conference were Messrs. Rick Muñoz (Chair), Michael Dunn, and David Wood and Ms. Cathy McGuire.

The conference was held as a result of the type, number, and severity level of violations noted during an Agency inspection conducted at the Licensee's facility on March 21, 2000, and a significant, unacceptable deficiency in the application and overall effectiveness of the radiation safety program.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notice of Violation, and the responses to the violations, were reviewed by Mr. Michael Dunn.

After reviewing the violations and responses, the Licensee's representatives were excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. The Licensee shall submit a certification statement from Sampth Sengaiya, that he has read, understands, and will abide by the Operating and Safety Procedures and Radiation Protection Program, to the Agency within 30 days of receipt of this memorandum.

2. A copy of the Licensee's Radiation Protection Program and Operating and Safety Procedures must be submitted to the Agency within 30 days of receipt of this memorandum.

3. The Licensee shall submit to the Agency a written commitment to perform audits of the Radiation Protection Program at 3 month intervals.

4. The Licensee shall send a copy of their new Radiation Protection Program records to the Agency within 30 days of receipt of this memorandum.

5. A copy of the transfer records received by Danny Harris, must be submitted to the Agency within 30 days of receipt of this memorandum.

6. A copy of the personnel monitoring records, for the period from the date of the alleged fire to the present, must be submitted to the Agency within 30 days of receipt of this memorandum. The Licensee shall also indicate the date that the fire occurred.

7. A copy of the Nuclear Medicine Technician's certification must be provided to the Agency within 30 days of receipt of this memorandum. Should any future staffing changes occur, copies of credentialing information, or a certification statement must be submitted to the Agency.

8. The Licensee shall submit a written commitment, that the facility will adhere to Radiation Safety Audits as prescribed in Appendix B of Regulatory Guide 3.1, within 30 days of receipt of this memorandum.

9. The fully executed Enforcement Conference Summary Memorandum will be used as a tie down license condition to the Licensee's license.

10. The Agency will increase the Licensee's inspection frequency and administrative penalties may be assessed pending the results of these inspections.

After the caucus, the Licensee's representatives returned and were informed of the items discussed during the caucus. They agreed to these items and the conference was concluded.

Enforcement Conference: Southwest Diagnostic Centers, Ltd. - Austin, Texas - Mammography

On May 18, 2000, an Enforcement Conference was held with Southwest Diagnostic Centers, Ltd. Registrant representatives attending the conference were Madames Paula Salvitti and Becky Naveira. Agency representatives attending the conference were Messrs. Rick Muñoz (Chair) and Jerry Cogburn and Madames Kaye Goss-Terry and Cathy McGuire.

The conference was held as a result of the type, number, and severity level of violations noted during an Agency inspection conducted at the Licensee's facility on February 23, 2000, and a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notice of Violation, and the responses to the violations, were reviewed by Mr. Jerry Cogburn.

After reviewing the violations and responses, the Licensee's representatives were excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. The Agency required a statement from Dr. Bryon D. Neely, general partner, stating that any mammography personnel has the authority to shutdown the mammography program should any tests cited in Section 289.230(l)(9)(B) fail. The statement must be provided to the Agency within 30 days of receipt of this memorandum.

2. The Registrant shall continue monthly meetings with the lead interpreting physician to review the QC program through May 1, 2001. Thereafter, the Registrant may return to the quarterly schedule. Documentation must be made available for future review.

3. The Registrant shall submit a written description of the medical audits review and analysis procedures to the Agency within 30 days of receipt of this memorandum.

4. The Notice of Failure may be removed at this time. A letter to that affect will be faxed to the Registrant.

5. The Agency will increase the Registrant's unannounced inspection frequency and administrative penalties may be assessed pending the results of these inspections.

After the caucus, the Registrant's representatives returned and were informed of the items discussed during the caucus. They agreed to these items and the conference was concluded.

Enforcement Conference: Linden Municipal Hospital - Linden, Texas - Mammography

On May 25, 2000, an Enforcement Conference was held with Linden Municipal Hospital. Registrant representatives attending the conference were Richard Arnold, Administrator and Kevin Westmoreland, Director of Radiology. Agency representatives attending the conference were Messrs. Quincy Wickson (Chair) and Jerry Cogburn and Madames Jo Turkette and Cathy McGuire.

The conference was held as a result of the type, number, and severity level of violations noted during an Agency inspection conducted at the Registrant's facility on February 3, 2000.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notices of Violation, and the responses to the violations, were reviewed by Mr. Jerry Cogburn.

After reviewing the violations and responses, the Registrant's representatives were excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. The Notice of Failure may be removed from posting.

2. A written request to add Nancy L. Hale, R.T., to the Certification of Mammogaphy Systems must be submitted to the Agency within 30 days of receipt of this memorandum.

3. Unannounced Agency inspections of the Registrant's facility will be performed on a continuing basis. If the results of these inspections show a significant improvement in the radiation safety program, the inspections will return to the routine frequency. Administrative penalties may be assessed pending the results of future inspections.

After the caucus, the Registrant's representative returned and was informed of the items discussed during the caucus. He agreed to these items and the conference was concluded.

Enforcement Conference: Jackson County Hospital District - Edna, Texas - Mammography

On May 30, 2000, an enforcement conference was held with Jackson County Hospital. Registrant representatives attending the conference were Madames Marcella V. Henke, Administrator, and Mary J. Chambliss, R.T. Agency representatives attending the conference were Messrs. Rick Muñoz (Chair), Jerry Cogburn, and Thomas Cardwell and Madames Kaye Goss-Terry and Cathy McGuire.

The conference was held as a result of the type, number, and severity level of violations noted during an Agency inspection conducted at the Registrant's facility on March 27, 2000, and a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notice of Violation, and the responses to the violations, were reviewed by Mr. Jerry Cogburn.

After reviewing the violation and response, the Licensee's representatives were excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Registrant shall notify all patients who had a mammogram performed 30 days prior to the March 27, 2000, inspection that the mammography system failed the Agency's certification standards; recommend that the patients have another mammogram performed at a facility with a certified mammography system; and list the three facilities closest to the original testing facility that have a certified mammography system. Notification must be made within 45 days of receipt of this memorandum and be approved by the Agency.

2. Mary Chambliss shall attend a Mammography Quality Control training class. The class must be a minimum of 8 hours and approved by the Agency.

3. The Registrant shall submit a signed and dated response from Dr. Truong attesting that he has reviewed quality control records and the period of time covered by the review.

4. Marcella Henke shall provide written commitment to documented monthly quality control program meetings with the interpreting physician for the period 6, 2000 through 6, 2001.

5. The Agency will increase the Registrant's unannounced inspection frequency and administrative penalties may be assessed pending the results of these inspections.

After the caucus, the Registrant's representatives returned and was informed of the items discussed during the caucus. He agreed to these items and the conference was concluded.

Enforcement Conference: McAllen Heart Hospital - McAllen, Texas - Medical

On June 6, 2000, an Enforcement Conference was held with McAllen Heart Hospital. Licensee representatives attending the conference were Messrs. Roy Vinson, President, Luis de Leon, Team Leader of Imaging, Dr. Allan Kapilivsky, R.S.O., and Ms. Tamara J. Cowen, R.N., Vice President of Clinical Services. Agency representatives attending the conference were Messrs. Rick Muñoz (Chair), Bob Green, and Scott Kee and Ms. Cathy McGuire.

The conference was held as a result of the type, number, and repetitive nature of violations noted during an Agency inspection conducted at the Licensee's facility on March 29, 2000, and a significant, unacceptable deficiency in the application and overall effectiveness of the radiation safety program.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notice of Violation, and the responses to the violations, were reviewed by Mr. Bob Green.

After reviewing the violations and responses, the Licensee's representatives were excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. The Licensee committed to documented monthly RSO audits of Mr. De Leon's weekly radiation safety reviews and to make the audits available to the Agency within 30 days of receipt of this memorandum.

2. The Licensee shall provide the Agency with a copy of the inventory checklist form within 30 days of receipt of this memorandum.

3. The Licensee shall conduct quarterly Radiation Safety Committee meetings beginning in August 2000 and continuing through August 2001. An attendees list and minutes for each meeting must be made available for the Agency's review.

4. The Agency will increase the Licensee's unannounced inspection frequency and administrative penalties may be assessed pending the results of these inspections

After the caucus, the Licensee's representatives returned and were informed of the items discussed during the caucus. They agreed to these items and the conference was concluded.

Enforcement Conference: Golden Plains Community Hospital - Borger, Texas - Mammography

On June 14, 2000, an Enforcement Conference was held with Golden Plains Community Hospital. Registrant representatives attending the conference were Messrs. Norm Lambert, Vicente Maza, M.D. and Richard Sandoval and Madames Patty Wilhite and Cynthia LaGrone. Agency representatives attending the conference were Messrs. Rick Muñoz (Chair), Jerry Cogburn, and Jack England and Madames Jo Turkette and Cathy McGuire.

The conference was held as a result of the type, number, and severity level of violations noted during an Agency inspection conducted at the Registrant's facility on April 24, 2000, and a significant, unacceptable deficiency in the application and overall effectiveness of their radiation safety program.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notice of Violation, and the responses to the violations, were reviewed by Mr. Jerry Cogburn.

After reviewing the violations and responses, the Registrant's representatives were excused while a caucus was held by the Agency representatives. During the caucus, the following was determined:

1. The Registrant shall notify all patients who received procedures during the period of April 26, 1999, through October 1, 1999. The notification letter must be approved by the Agency prior to posting.

2. The Lead Interpreting Physician and Director of Radiology shall conduct and document a monthly review of the mammography quality control program and have information available for review during the next inspection. The review must be conducted for a period of twelve months starting from the date of receipt of this memorandum.

3. The Agency will increase the Registrant's unannounced inspection frequency and administrative penalties may be assessed pending the results of these inspections.

After the caucus, the Registrant's representatives were informed of the items discussed during the caucus. They agreed to these items and the conference was concluded.

Enforcement Conference: Kooney X-Ray, Inc., Mariano Castro, and Leonardo Garcia - Baker, Texas - Industrial Radiography

On June 22, 2000, an Enforcement Conference was held with Kooney X-Ray, Inc. Licensee representatives attending the conference were Messrs. Stewart Frazier, R.S.O., Bruce Bristol, Consultant, Gary Maze, Leonardo Garcia, Mariano Castro, and Don Abito. Agency representatives attending the conference were Messrs. Rick Muñoz (Chair), James L. Thompson, William Stringfellow, and William Silva and Madames Kitty Knebel, Jan Endahl, Ronda Sanders, and Cathy McGuire.

The conference was held as a result of an Agency field site inspection conducted on March 21, 2000. This inspection determined the Licensee had a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

The participants were introduced and the procedure for conducting the conference was explained.

The violations cited in the Notice of Violation, and the responses to the violations, were reviewed by Ms. Kitty Knebel.

After reviewing the violation and response, the Licensee's representatives were excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Licensee shall provide a written commitment to the Agency stating the facility will conduct internal site/field audits of crew members at intervals not to exceed 3 months for a period of one year. The audits will begin July 1, 2000, and continue through July 1, 2001. Documentation of site/field audits must be made available for Agency review.

2. The Licensee shall submit a written request to the Agency to remove Mariano Castro from the license as a trainer for at least six months and, prior to reinstatement as a trainer, will provide the Agency with documentation that Mr. Castro successfully completed an Agency approved 40 hour Radiation Safety Training course.

3. Mr. Garcia must take an Agency approved 40 hour Radiation Safety Training course within 3 months of the date of this enforcement conference summary. If he does not complete the course within the 3 month period, his Trainer status may be removed.

4. Administrative penalties may be assessed pending the outcome of future inspections.

After the caucus, the Licensee's representatives returned and were informed of the items discussed during the caucus. They agreed to these items and the conference was concluded.